Encephalitis Case History Form

(*Do not fill out West Nile case history form if this form is completed*)

Serum, **CSF** & this **case history form** are required for testing (specimens will not be tested without this form)!
Consent is required for advanced diagnostic testing
NP/throat and **stool/rectal** specimens are recommended

Case patients must be hospitalized with encephalopathy (depressed or altered level of consciousness ≥24 hours, lethargy, or change in personality) or ataxia, **AND** have 1 or more of the following: fever (T≥38C), seizure(s), focal neurologic findings, CSF pleocytosis, abnormal EEG or neuroimaging study. Case patients must be ≥ 6 months of age and immunocompetent.

Patient Information:

Last name _____ First name_____DOB ____/_____/____ Medical Record #_____

Street Address: _____City _____Zip Code _____Occupation_____

Telephone #: _____ Name of Surrogate decision-maker and/or Guardian: _____

Race: ❑ White ❑ Black ❑ Native American ❑ Asian/Pacific Islander ❑ Other ❑ Unknown

Ethnicity: ❑ Hispanic ❑ Non-hispanic

Sex: ❑ Female ❑ Male

Exposures 1 mo before onset (specify details):

Any animal contact (including pets): ❑ No ❑ Yes

Tick bites/exposure: ❑ No ❑ Yes

Mosquito bites/exposure: ❑ No ❑ Yes

Other insect bites: ❑ No ❑ Yes

Day care (patient or siblings): ❑ No ❑ Yes

Immunizations up to date?: ❑ No ❑ Yes

Immunizations in last month?: ❑ No ❑ Yes

Medications (including OTC): ❑ No ❑ Yes

Toxins or illicit drugs: ❑ No ❑ Yes

Fresh water (swimming or drinking) ❑ No ❑ Yes

Ingestion of soil ❑ No ❑ Yes

Fish Ingestion (marine, freshwater) ❑ No ❑ Yes

Head Trauma ❑ No ❑ Yes

Outdoor activity (camping, hiking, etc) ❑ No ❑ Yes

Sick Contacts ❑ No ❑ Yes

Travel 1 mo before onset
(specify location, dates, and mode of transportation):

Outside of United States: ❑ No ❑ Yes

In United States: ❑ No ❑ Yes

In State (out of local area): ❑ No ❑ Yes

Additional Information (please provide details):

Is the patient homeless? ❑ No ❑ Yes

Ever traveled outside the US? ❑ No ❑ Yes

Known TB exposures? ❑ No ❑ Yes

Previous PPD test? ❑ No ❑ Yes

Significant Past History (medical, social, family, including rheumatologic disorders, early organ failure):

Miscellaneous exposures or potentially pertinent information:

Patient Name:

Clinical:
Date of first CNS symptom(s): ____/____/____
Date of hospital admission: ____/____/____
Do the following apply anytime during current illness:
In ICU ❑ No ❑ Yes _____
Fever ≥38º ❑ No ❑ Yes _____
Lethargy ❑ No ❑ Yes _____
Alt. conscious ❑ No ❑ Yes _____
Personality Δ ❑ No ❑ Yes _____
Extreme irritability ❑ No ❑ Yes _____
Hallucinations ❑ No ❑ Yes _____
Stiff neck ❑ No ❑ Yes _____
Ataxia ❑ No ❑ Yes _____
Somnolence ❑ No ❑ Yes _____
Focal neuro ❑ No ❑ Yes _____
Seizures ❑ No ❑ Yes _____
intractable? ❑ No ❑ Yes _____
Coma ❑ No ❑ Yes _____
pheno/pentobarb? ❑ No ❑ Yes _____
Other symptoms (1 mo before onset. Provide details)
URI or ILI ❑ No ❑ Yes _____
GI ❑ No ❑ Yes _____
CV ❑ No ❑ Yes _____
Rash ❑ No ❑ Yes _____
Brain MRI date___/___/___ ❑ Normal ❑ Abnormal ❑ND
If abnormal: ❑ temporal lobe involvement
❑ white matter involvement
❑ hydrocephalus
❑ other_____
_____
Brain CT date___/___/___ ❑ Normal ❑ Abnormal ❑ND
If abnormal: ❑ temporal lobe involvement
❑ white matter involvement
❑ hydrocephalus
❑ other_____
_____

EEG date: ____/____/____ ❑ Normal ❑ Abnormal ❑ND
If abnormal: ❑ diffuse slowing
❑ focal temporal epileptiform activity
❑ PLEDS
❑ other_____
_____

CBC results (first available & subsequent):
Date: _____ _____
WBC: _____ _____
Diff: _____ _____
HCT _____ _____
Plt: _____ _____

CSF results (first & subsequent):
Date: _____ _____
OP: _____ _____
RBC: _____ _____
WBC: _____ _____
%Diff: _____ _____
Protein _____ _____
Glucose _____ _____
CrAg _____ _____
VDRL _____ _____

Was HSV PCR sent? ❑ No ❑ Yes
If yes, please give result & CSF date:_____

Other labs/Xrays (if performed. List results if abnormal)
LFTs ❑ Normal ❑ Abnormal _____
BUN/Cr ❑ Normal ❑ Abnormal _____
ESR ❑ Normal ❑ Abnormal _____
ANA ❑ Normal ❑ Abnormal _____
Tox screen ❑ Normal ❑ Abnormal _____
Heavy metals ❑ Normal ❑ Abnormal _____
CXR ❑ Normal ❑ Abnormal _____
Other_____

Microbiologic studies/results:
_____
_____
_____
_____
_____
_____
_____

Treatment (specify type & date started):
Antiviral agents_____Antibacterial agents_____
Steroids/IVIG _____

Contact Physician Information (MANDATORY – FOR OBTAINING UPDATES AND RELAYING RESULTS):
Name: _____ **Facility:** _____
Pager: _____ **Fax:** _____ **e-mail:** _____

Questions regarding project or specimens contact Somayeh Honarmand (510) 307-8608 or pager (510) 641-5286

Fax this form to **(510) 307-8599** or send with specimens to:
Specimen Receiving
Encephalitis Project
850 Marina Bay Parkway, Richmond, CA 94804